



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

APPLICATION FOR LICENSE TO OPERATE A CHILD CARE FACILITY

IDENTIFYING INFORMATION

LEGAL NAME OF FACILITY	<input type="checkbox"/> FAMILY HOME	<input type="checkbox"/> APPLICANT'S RESIDENCE
FACILITY ADDRESS (STREET, CITY, STATE, ZIP CODE)	<input type="checkbox"/> GROUP CHILD CARE HOME	<input type="checkbox"/> OTHER LOCATION
MAILING ADDRESS (STREET, CITY, STATE, ZIP CODE)	<input type="checkbox"/> CHILD CARE CENTER	
DIRECTIONS TO THE FACILITY	<input type="checkbox"/> SCHOOL AGE PROGRAM ON SCHOOL PROPERTY	
	COUNTY	
	FACILITY PHONE NUMBER	
IS FACILITY CURRENTLY LICENSED BY ANY OTHER AGENCY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES EXPLAIN: _____	EMAIL ADDRESS	

ADMINISTRATION (Attach additional pages as needed).

LIST ALL NAME(S) OF OWNER(S), ORGANIZATION OF CORPORATION OPERATING CHILD CARE FACILITY

NAME	SOCIAL SECURITY NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER
IS OWNERSHIP REGISTERED WITH OFFICE OF SECRETARY OF STATE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE CHECK: <input type="checkbox"/> FICTITIOUS NAME <input type="checkbox"/> CORPORATION <input type="checkbox"/> LLC <input type="checkbox"/> OTHER: _____	
NAME OF BOARD PRESIDENT/CHAIRPERSON/LLC MEMBER	SOCIAL SECURITY NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER

LIST NAME OF DIRECTOR/GROUP CHILD CARE HOME PROVIDER/FAMILY HOME CHILD CARE PROVIDER

NAME	SOCIAL SECURITY NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER

PHYSICAL PLANT

FLOOR(S) FOR CHILD CARE <input type="checkbox"/> BASEMENT <input type="checkbox"/> 1 ST FLOOR <input type="checkbox"/> 2 ND FLOOR <input type="checkbox"/> OTHER: _____	WATER SYSTEM <input type="checkbox"/> PUBLIC <input type="checkbox"/> PRIVATE <input type="checkbox"/> OTHER: _____
SOURCE AND TYPE OF HEATING SYSTEM	SEWAGE DISPOSAL SYSTEM <input type="checkbox"/> PUBLIC <input type="checkbox"/> PRIVATE <input type="checkbox"/> OTHER: _____

LICENSE SPECIFICATIONS REQUESTED

_____ TOTAL CAPACITY OF CHILDREN AT ONE TIME	AGE RANGE OF CHILDREN	HOURS OF OPERATION
INCLUDING _____ CHILDREN UNDER 24 MONTHS	_____ THROUGH _____	<input type="checkbox"/> 6:00AM - 9:00PM (DAYTIME) <input type="checkbox"/> 9:00PM - 6:00AM (NIGHTTIME) <input type="checkbox"/> 6:00AM - 6:00AM (24 HOUR CARE)
DAY OF OPERATION (CHECK ANY THAT APPLY) <input type="checkbox"/> SUN <input type="checkbox"/> MON <input type="checkbox"/> TUE <input type="checkbox"/> WED <input type="checkbox"/> THU <input type="checkbox"/> FRI <input type="checkbox"/> SAT		
MONTHS OF OPERATION (CHECK ANY THAT APPLY) <input type="checkbox"/> ALL 12 MONTHS <input type="checkbox"/> JAN <input type="checkbox"/> FEB <input type="checkbox"/> MAR <input type="checkbox"/> APR <input type="checkbox"/> MAY <input type="checkbox"/> JUN <input type="checkbox"/> JUL <input type="checkbox"/> AUG <input type="checkbox"/> SEP <input type="checkbox"/> OCT <input type="checkbox"/> NOV <input type="checkbox"/> DEC		

PLEASE READ PRIOR TO SIGNING APPLICATION

I/we understand and acknowledge:

- A. That I/we have read, understand, and agree to comply with all applicable statutes and licensing rules which can be found at <https://health.mo.gov/safety/childcare/lawsregs.php>.
- B. A license will be granted when facility has been determined in compliance with state statutes and licensing rules.
- C. If rules are not met within six months of the filing date, this application shall be void.
- D. The license is not transferable and applies only to the person(s) and address shown on the license.
- E. The license may be subject to revocation or other disciplinary actions for failure to maintain compliance with state statutes and licensing rules.
- F. The licensing record is open to the public for review, if requested.
- G. I/we agree to accept and provide care to children without regard to race, sex, religion, national origin, or disability.

**THE UNDERSIGNED IS THE PERSON(S) RESPONSIBLE FOR THE INFORMATION GIVEN
AND STATES THAT INFORMATION IS TRUE AND ACCURATE.**

SIGNATURE OF OWNER(S)/BOARD CHAIRPERSON/LLC MEMBER/DESIGNEE (CIRCLE APPROPRIATE TITLE)		
SIGNATURE	PRINT NAME	DATE